

APPLICATION FOR MEMBERSHIP



I, (Mr, Mrs, Ms or Miss) _____
(first & last name of applicant)

Of

_____ (full address including suburb
and postcode)

Please indicate if you are of Aboriginal and/or Torres Strait Islander descent:

Aboriginal

Torres Strait Islander

Non-Indigenous

APPLY FOR MEMBERSHIP to the Townsville Aboriginal and Torres Strait Islander Corporation for Health Services.

Signature of Applicant

Date

Office Use Only

Application tabled at Board meeting held on	Date:
Resolution number	Resolution Number:
Directors confirmed applicant is eligible for membership	YES / NO
Entered on register of members	Date:

Chairperson's Signature

Our Culture. Our Health. Our Way.

Townsville Aboriginal & Islander Health Service

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